STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185361	A. BUILDING _____ B. WING _____	07/01/2010

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KINDRED HOSPITAL - LOUISVILLE	1313 ST. ANTHONY PLACE LOUISVILLE, KY 40205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Amended CMS 2567L issued to the facility on 07/21/10. A standard survey was conducted 06/29/10 through 07/01/10. Deficiencies were cited with the highest scope and severity of a "J". Immediate Jeopardy was identified on 06/29/10 with the facility being notified on 06/29/10. Immediate Jeopardy was identified at 483.65, Infection Control. The facility provided a Credible Allegation of Compliance on 07/01/10. The State Agency verified Immediate Jeopardy was removed on 07/01/10, which lowered the scope and severity to a "D" at 42 CFR 483.65, Infection Control, F441.	F 000		
F 272 SS=D	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status;	F 272	**F 272483.20 483.20(b) COMPREHENSIVE ASSESSMENTS** **How the corrective action will be accomplished** Minimal Data Set (MDS) Coordinator will complete a comprehensive admission assessment on Resident # 6 & # 7 using the RAI process **How the facility will identify other residents affected by the deficient practice.** The MDS Coordinator will conduct a review of missing comprehensive admission assessments and RAPs and develop a schedule to complete assessments/RAPs identified through this process.	07/21/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: X Mike Maxwell — TITLE: X Administrator — (X6) DATE: 7/26/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 272	Continued From page 1 Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to complete a comprehensive assessment for two (2) of twelve (12) sampled residents. The facility must conduct an initial comprehensive assessment which is accurate in order to provide appropriate care. The facility failed to complete admission assessments for Resident #6 and Resident #7. The findings include: Review of the clinical record for Resident #6 revealed he/she was admitted on 05/26/10 for respiratory care. Resident #6 has a tracheostomy and is dependent on a mechanical ventilator to breath. On 06/29/10 there was no documentation of a Resident Assessment Instrument (RAI)/Resident Assessment Protocol (RAP) documented in the record. Record review of Resident #7 revealed no comprehensive admission assessment. Resident #7 was admitted on 06/04/10 with the diagnoses of Chronic Respiratory Failure, Chronic Obstructive Pulmonary Disease, and Insulin Dependent Diabetes Mellitus. The resident is	F 272	**What measures will be put into place to ensure no reoccurrence** 1. The MDS Coordinator acknowledged understanding of the MDS Admission Assessment completion requirements to DNS and the District Director of Case Management. 2. The MDS Alert Report will be ran weekly to review the status of resident assessment due date(s). 3. Appropriate training and back up personnel will be in place to ensure timely completion of MDS Assessments as necessary, including covering for MDS Coordinator during PTO/ LOA. **How effectiveness of changes will be monitored to ensure that solutions are sustained.** The Director of Nursing, or her designee, will monitor through review of comprehensive	

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F 272	Continued From page 2 ventilator dependent. Interview with the Director of Nursing (DON) on 07/01/10 at 8:00am revealed the Minimum Data Set Coordinator was on leave for approximately five weeks. The DON stated she was trying to do the Minimum Data Set (MDS) assessments but was unable to complete the assessments according to the required time frames. She stated the district care manager and someone from another facility were also working with her to complete the assessments. The previous MDS Coordinator recently resigned and was going to work as needed to assist in completing the assessments. However, she did not return to work. Interview with the Minimum Data Set (MDS) coordinator on 06/29/10 at 11:50am revealed she was a new employee and was not aware the MDS for Residents #6 and Resident #7 had not been completed.	F 272	assessments/RAPs and , the MDS Alert Reports at least weekly for 1 month, then monthly for three months, then at least quarterly, to assure each resident is assessed according to regulation. The results will also be discussed/ reviewed with the District Director of Case Management. Status of the MDS Assessments will be presented monthly at the monthly Quality Assurance Committee Meeting. The Administrator is responsible for overall compliance. **Responsible Person** The Administrator is responsible for overall compliance.	
F 276 SS=E	483.20(c) QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined the facility failed to complete the quarterly review assessments within the three month time frame as required for three (3) of fourteen (14) sampled residents (Residents #12, #13, and #14).	F 276	**F 276 483.20 (c) QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS** **How the corrective action will be accomplished** Residents 12, 13, and 14 have completed Quarterly MDS Assessments, and future quarterly assessments will be completed timely for these residents. Appropriate training and back up personnel will be in place to	07/21/10

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F 276	Continued From page 3 The findings include: Record review of Resident #12 revealed the admission assessment was completed on 02/02/10. The quarterly assessment was completed on 06/10/10. Record review of Resident #13 revealed the quarterly assessment was completed on 01/21/10. The next quarterly assessment was not completed until 05/20/10. Record review of Resident #14 revealed the quarterly assessment was completed on 02/18/10. The next assessment was not completed until 06/10/10. Interview with the Director of Nursing (DON) on 07/01/10 at 8:00am revealed the Minimum Data Set Coordinator was on leave for approximately five weeks. The DON stated she was trying to do the Minimum Data Set (MDS) assessments but was unable to complete the assessments according to the required time frames. She stated the district care manager and someone from another facility were also working with her to complete the assessments. The previous MDS Coordinator recently resigned and was going to work on an as needed basis to assist in completing the assessments. However, she did not return to work. Interview with the Minimum Data Set Coordinator on 06/29/10 at 11:50am revealed she was not current with the Minimum Data Set (MDS) assessments. She stated she had been on leave and had recently returned to work.	F 276	ensure timely completion of MDS Assessments as necessary, including covering for MDS Coordinator during PTO/ LOA. **How the facility will identify other residents affected by the deficient practice.** The MDS Coordinator conducted a review of other residents to identify any resident whose quarterly assessment is past due and developed a schedule for timely completion for those identified through this process. All MDS Assessment Reviews are current for all residents currently on the SAU. **What measures will be put into place to ensure no reoccurrence** 4. The MDS Coordinator acknowledged understanding of the MDS Assessment completion requirements to DNS and the District Director of Case Management.	
F 441	483.65 INFECTION CONTROL, PREVENT	F 441		

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F 276	Continued From page 3 The findings include: Record review of Resident #12 revealed the admission assessment was completed on 02/02/10. The quarterly assessment was completed on 06/10/10. Record review of Resident #13 revealed the quarterly assessment was completed on 01/21/10. The next quarterly assessment was not completed until 05/20/10. Record review of Resident #14 revealed the quarterly assessment was completed on 02/18/10. The next assessment was not completed until 06/10/10. Interview with the Director of Nursing (DON) on 07/01/10 at 8:00am revealed the Minimum Data Set Coordinator was on leave for approximately five weeks. The DON stated she was trying to do the Minimum Data Set (MDS) assessments but was unable to complete the assessments according to the required time frames. She stated the district care manager and someone from another facility were also working with her to complete the assessments. The previous MDS Coordinator recently resigned and was going to work on an as needed basis to assist in completing the assessments. However, she did not return to work. Interview with the Minimum Data Set Coordinator on 06/29/10 at 11:50am revealed she was not current with the Minimum Data Set (MDS) assessments. She stated she had been on leave and had recently returned to work.	F 276	5. The MDS Alert Report will be ran weekly by MDS Coordinator to review the status of resident assessment due date(s). **How effectiveness of changes will be monitored to ensure that solutions are sustained.** The Director of Nursing, or her designee, will monitor through review of quarterly assessments/RAPs and, the MDS Alert Reports at least weekly for 1 month, then monthly for three months, then at least quarterly, to assure each resident is assessed according to regulation. The results will also be discussed/ reviewed with the District Director of Case Management. Status of the MDS Assessments will be presently monthly at the monthly Quality Assurance Committee Meeting. The Administrator is responsible for overall compliance. **Responsible Person** The Administrator is responsible for overall compliance.	
F 441	483.65 INFECTION CONTROL, PREVENT	F 441		

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F 441 SS=J	Continued From page 4 SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441	**F441 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS** **How the corrective action will be accomplished** Education and counseling of the nurse who did not clean the glucometer between two patients was done by the Director of Nursing Services and the Infection Control Practitioner immediately on June 29, 2010. The nurse understands the practice expectations of following infection control policies. **How the facility will identify other residents affected by the deficient practice.** The policy on Infection Control related to cleaning equipment between patients was reviewed with every nurse by the Director of Nursing Services and the Infection Control Practitioner working on the Sub Acute unit 06/29/10 thru 07/01/10. Continued education will be conducted by the Infection Control Practitioner and/or	07/21/10

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F 441	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, it was determined the facility failed to prevent the spread of infection by not sanitizing the multi-use glucometer between blood glucose testing of Residents #7 and #11 who were identified by the facility as requiring contact isolation precautions. The facility staff failed to follow the "Infection Control" policy and procedure. On 06/29/10, LPN #1 was observed not sanitizing the multi-use glucometer between blood glucose testing of two residents. Resident #7 required contact precautions for Multi Drug Resistant A Baumannii. Resident #11 required contact precautions for Methicillin Drug Resistant Staph Aureus. The facility identified twenty nine (29) residents out of a census of thirty seven (37) to need contact isolation precautions. This failure of the facility on 06/29/10 was found to likely cause serious injury, harm, impairment or death to residents' health and safety. On 07/01/10 the facility submitted a Credible Allegation of Compliance at which time it was determined the Immediate Jeopardy was removed which lowered the scope and severity to a "D" while the facility monitors the consistency of the sanitation of the glucometers to ensure appropriate techniques and interventions are put in place for residents at risk for infection. The findings include: The facility policy on Infection Control dated 07/1999 with a revision date of 05/2010 stated when possible, dedicate the use of noncritical patient care equipment. If this is not possible, then the equipment must be cleaned and	F 441	Director of Nursing Services until all 20 nurses assigned to the Sub Acute Units have received the education. This education will be completed prior to the nurses starting their shift. This education is documented. **What measures will be put into place to ensure no reoccurrence** Immediate education of all nurses on the Sub Acute units began on June 29, 2010 with the 7:00 a.m shift. This education was done by the Infection Practitioner and the Director of Nursing Services. The education included a review of the Infection Control policy on Multi Drug Resistant Organisms (MDROs) as well as a review of a Story Board on "*Cleaning Equipment In and Out of the Resident Room.*" The education has been completed for all 20 nurses employed on the Sub Acute unit. Any nurse hired after July 1, 2010 will not be allowed to work until he/she	

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F 441	Continued From page 6 disinfected before use on another patient using hospital approved disinfectant. The policy also states all patients with known MDRO (Multi Drug Resistant Organisms) or who have previously been identified as colonized with MDROs, will be placed in contact precautions. Observation on 06/29/10 at 11:40am revealed a contact precaution sign outside the room of Resident #11 (room 318) and a contact precaution sign outside the room of Resident #7 (room 320). Observation of Licensed Practical Nurse (LPN) #1 on 06/29/10 at 11:40am revealed she took the glucometer into Resident #11's room to perform the blood glucose test by using the glucometer (pricked the fingertip for a droplet of blood placed on the glucometer strip, then tested by the glucometer) to determine the resident's blood sugar level. She put on personal protective equipment, gown and gloves. LPN #1 proceeded to perform the finger stick. After obtaining the reading she removed her gown and gloves and sanitized her hands. She then exited the room to take the glucometer to Resident #7's room. The LPN then put on a gown and gloves and performed the same blood glucose test on Resident #7. After performing the test, she removed her gown and gloves and sanitized her hands. Upon exiting Resident #7's room, LPN #1 cleaned the glucometer with a Clorox wipe. At no time during this observation did the LPN clean the glucometer between testing of Residents #11 and #7. Interview with LPN #1 revealed she should have cleaned the glucometer between resident use. Record review revealed Resident #7 was	F 441	has received the aforementioned Infection Control Training during Orientation by the Infection Control Practitioner. Appropriate disinfectant will be readily available to staff. A written protocol for cleansing of the glucometer machines was also placed on the medication carts for the nurses' reference. This protocol and the inservicing that has been conducted is consistent with the manufacturer's instructions for care and maintenance of the machine. **How effectiveness of changes will be monitored to ensure that solutions are sustained.** Each Sub Acute Nurse will be observed for evidence that they are compliant with the Infection Control policy and procedure. This observation began 06/29/10 by the Infection Control Practitioner and the Director of Nursing Services and the education is	

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F 441	Continued From page 7 admitted on 06/04/10 having diagnoses of Chronic Obstructive Pulmonary Disease, Chronic Respiratory Failure, Congestive Heart Failure, Pneumonia, Insulin Dependent Diabetes Mellitus, and Multi Drug Resistant A Baumannii. Physician's orders revealed the resident was to have a finger stick blood glucose performed every six hours and receive sliding scale insulin according to the results. Record review revealed the facility admitted Resident #11 on 04/10/10 having diagnoses of Chronic Obstructive Pulmonary disease, Coronary Artery Disease, Insulin Dependent Diabetes Mellitus and Methicillin Drug Resistant Staph Aureus. Physician's orders revealed the resident was to have a finger stick blood glucose performed every six hours and receive sliding scale insulin according to the glucose reading. Interview with Licensed Practical Nurse (LPN) #1 on 06/29/10 at 11:40am revealed she knew she should clean the glucometer between residents. Interview with LPN #2, on 06/30/10 at 7:55am, revealed the facility practice was to clean the glucometer between residents with Clorox wipes. Interview with Certified Nursing Assistant (CNA) #1, on 06/29/10 at 4:00pm, revealed all equipment such as blood pressure machines, scales, chairs, and Hoyer lifts need to be cleaned after each resident encounter. Interview with CNA #2, on 06/29/10 at 4:20pm, revealed all equipment taken from room to room should be cleaned with Clorox wipes. Interview with the Infection Control Nurse, on	F 441	documented. Weekly observations will occur by the Director of Nursing Services or the Infection Control Practitioner to validate compliance. In the event that policy and procedure is not followed, on the spot remediation will be conducted with the nurse and documented. The cleaning procedure will be reviewed and observed until full and satisfactory compliance is achieved. Afterwards, monthy rounds by the Director of Nursing Services or Infection Control Practitioner will continue to ensure ongoing compliance. All newly hired licensed staff will be trained by the Infection Control Practitioner during orientation to the facility on the Infection Control policy and protocol for cleaning the glucometer machines. All staff in the facility will be trained by the Infection Control Practitioner annually on the Infection Control policies and cleaning of the glucometer machines.	

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F 441	Continued From page 8 06/29/10 at 3:00pm, revealed it is the expectation that all shared resident care equipment be cleaned with Clorox wipes. This included the glucometers. She also stated while both Resident #7 and Resident #11 had colonized infections, even colonized infections can potentially cause harm. She stated the facility followed the Center for Disease Control guidelines by continuing contact precautions for residents with multi drug resistant infections for the remainder of their stay. Interview with the Director of Nursing (DON), on 06/29/10 at 4:00pm, revealed the staff had an in-service on infection control in either January or February of 2010 on cleaning equipment. She stated only licensed (LPN/ RN) staff do the glucose testing. She stated failure to clean the glucometer could lead to the spread of infections among residents. The DON expected staff to clean equipment between residents and this included the glucometer. The manufacture's meter operators guide for the SureStepFlexx (Professional Blood Glucose Management System) does not specifically state the meter is multiuse. However, the booklet contains instructions for using the bar code scanner to identify the patient and instructions on how to view all patient results for the last 31 days. In addition, the facility cleaning procedure identified staff should clean the outside of the meter after every patient use with a cloth dampened with a 10% bleach solution. The Administrator and the DON were notified of the Immediate Jeopardy on 06/29/10. The facility provided an acceptable Credible Allegation of compliance on 07/01/10.	F 441	The Quality Assurance Committee will review the findings monthly of the licensed nurse education on Infection Control policies and the weekly licensed nurse observations of glucometer cleaning between each use. The Director of Nursing will report the findings of the reviews to the Quality Assurance Committee at the monthly meeting. The results of the glucometer cleaning observations will be tracked and trended with follow up actions or education for staff completed as necessary. Once the Quality Assurance Committee validates compliance has been sustained, the monitoring schedule will be adjusted. **Responsible Party** The Administrator is responsible for overall compliance	

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F 441	Continued From page 9 On 06/29/10, Education and counseling, of the nurse who did not use the Clorox wipes to clean the glucometer between two residents, by the DON and Infection Control Practitioner. A review of the facility's education and training records revealed the policy on infection control relating to cleaning the equipment between residents was reviewed with Sub Acute unit nurses by 06/29/10 and other nurses not working on that date by 07/01/10. Record review of facility education files revealed a story board on cleaning equipment in and out of the resident room was reviewed with nursing staff 06/29 - 30/10 with the remainder of staff required to review prior to working their scheduled shift. Observation on 07/01/10 at 2:55pm revealed Clorox wipes were placed on the medication carts in close proximity to the glucometers as was the written protocol for cleaning the glucometer. Record review revealed an audit tool was put into place on 07/01/10 that listed each employee responsible for the audit and the weeks the audits were required. Every nurse will be observed by the Infection Control Practitioner and the DON at least once for evidence that they are compliant with cleaning the equipment between patients. Weekly observations will occur by the DON or the Infection Control Practitioner to validate compliance. All newly hired licensed staff will be trained by the Infection Control Practitioner during orientation. All facility staff will be trained annually on cleaning the glucometer. The Performance Improvement Committee will review the findings monthly regarding the licensed nurse observations of the glucometer cleaning and adjust the monitoring according to findings.	F 441		

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KINDRED HOSPITAL - LOUISVILLE	1313 ST. ANTHONY PLACE LOUISVILLE, KY 40205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 10 Interview with LPN #3, on 07/01/10 at 2:35pm, revealed she had received training on 06/29/10 regarding the cleaning of the glucometer. Interview with LPN #4 on 07/01/10 at 2:45pm revealed she was in-serviced on cleaning the glucometer between residents with Clorox wipes and stated there was an orange card on the medication cart as a reminder. Interview with LPN #5, on 07/01/10 at 2:30pm, revealed she was in-serviced on 07/01/10 on cleaning the glucometer with Clorox wipes after each resident use. On 07/01/10 the facility submitted a Credible Allegation of Compliance at which time it was determined the Immediate Jeopardy was removed which lowered the scope and severity to a "D" while the facility continues to monitor quality assurance, reviews, all staff training, and assesses to ensure compliance.	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185361	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	07/08/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED HOSPITAL - LOUISVILLE	1313 ST. ANTHONY PLACE LOUISVILLE, KY 40205

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K 000	INITIAL COMMENTS A Life Safety Code survey was initiated and concluded on 07/08/2010. The facility was found not to meet the minimal requirements with 42 Code of the Federal Regulations, Part 483.70. The highest scope and severity deficiency identified was a "D".	K 000		
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to maintain the fire sprinkler system according to NFPA standards. The findings include: Observation on 07/08/10 at 11:50AM revealed the fire sprinkler head in the shower room was improperly orientated, causing the sprinkler head not to point in the proper direction. The Plant Operations Manager was present during the observation. Interview on 07/08/10 at 11:50AM, with the Plant Operations Manager, revealed the fire sprinkler heads were inspected monthly. The Plant Operations Manager stated that ceiling tiles had recently been replaced and may have been the reason the fire sprinkler head is not orientated in the right direction. The Plant operations Manager had the problem corrected at that time.	K 062	**How The Corrective Action will be accomplished** It is the practice of this facility to assure that the sprinkler system is continuously maintained in reliable operating condition, and is inspected and tested periodically to ensure compliance at all times with Life Safety Code. The incorrectly positioned sprinkler head was immediately corrected on 7/8/2010 in the shower room on 3 East. **How the facility will identify other residents affected by the deficient practice** The following intervention was taken to prevent potential residents from being affected: All sprinkler heads on SNU were inspected and no other deficient sprinkler heads were found.	07/16/10

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Mike Morrell | Administrator | 7/26/10

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ther safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days llowing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 ays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued rogram participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185361	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	07/08/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED HOSPITAL - LOUISVILLE	1313 ST. ANTHONY PLACE LOUISVILLE, KY 40205

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K 062	Continued From page 1 Reference: NFPA 25 (1999 edition) 2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation.	K 062	**What measures will be put into place to ensure no reoccurrence** The Director of Plant Operations, or designee will continue to make routine monthly safety inspections of the building to make sure that the above and any other Life Safety Standard remain in compliance. In addition, the sprinker system will be checked by the Maintenance Department immediately following the completion of any work pertaining to the ceiling, or any work that has the potential to alter the sprinkler system. Any deficiencies will be reported to the Administrator and will be immediately repaired. **How effectiveness of changes will be monitored to ensure that solutions are sustained.** The process will be monitored by our SNU Quality Assurance (QA) Committee to ensure completion of Life Safety Rounds. All future issues related to Life Safety Standards will be brought to the attention of tthe SNU QA Committee by the Director of Plant Ops. Monthly safety inspections will continue to be reviewed by the Environment of Care Committee, withmonthly reports to the SNU QA Committee as applicable. **Responsible Person** The Administrator is responsible for overall compliance.	

CABINET FOR HEATH SERVICES
OFFICE OF INSPECTOR GENERAL
DIVISION OF HEATH CARE FACILITIES

TYPE "A" CITATION

FACILITY NAME: Kindred Skilled Nursing Unit
1313 St. Anthony Place
Louisville, Kentucky 40205

ADMINISTRATOR: Mike Maxwell

Date: July 06, 2010

This citation is issued pursuant to KRS 216.510, KRS 216.525, and 900 KAR 2:040 for the violation of 902 KAR 20:300 Section 6(7)(b)2.a. This citation may be appealed according to the provisions of 900 KAR 2:020, which state that a written request for a hearing must be made to the Secretary of the Cabinet for Heath Services within twenty (20) days of the receipt of the written notice of the action. Any penalty assessed for this citation may be appealed under the same provisions.

During a standard survey conducted on 06/29 through 07/01/10, it was determined the facility failed to ensure the facility's infection control policies and procedures were implemented and followed by staff. This failure led to the facility's failure to prevent the potential spread of infection between residents. The facility failed to ensure their infection control policy was implemented regarding the cleaning of the glucometer (a device which tests blood glucose levels) for two (2) residents, (#7 and #11) out of twenty nine (29) residents who were in isolation due to an active or having a history of contagious infection. The facility policy on infection prevention and control practices, dated 07/1999 and reviewed 05/2010, states when equipment is not dedicated to a specific resident, then the equipment must be cleaned and disinfected before use on another patient using hospital approved disinfectant. On 06/29/2010 at 11:40am, Licensed Practical Nurse (LPN) #1 was observed taking the glucometer into Resident #11's room, performing the blood glucose test through the use of the glucometer (pricked the fingertip for a droplet of blood placed on the glucometer strip, then tested by the glucometer) to determine the residents blood sugar level, then proceeded to take the glucometer to Resident #7's room and performed the same blood glucose test on Resident #7. At no time during this observation did the LPN clean the glucometer between uses for Residents #11 and #7. Resident #11 was in contact isolation for the infection Methicillin Resistant Staph Aureus and Resident #7 was in contact isolation for the infection Multi Drug Resistant A Baumanii.

Interview with LPN #2 on 06/30/10 revealed the facility practice was to clean the glucometer between residents with Clorox wipes. Interview with the Certified Nursing Assistant (CNA) #1 on 06/29/10 revealed all equipment such as blood pressure machines, scales, chairs, and hoyer lifts need to be

cleaned after each resident encounter. Interview with CNA #2 on 06/29/10 revealed all equipment taken from room to room should be cleaned with Clorox wipes.

The Infection control Nurse stated it is the expectation that all shared resident care equipment be cleaned with Clorox wipes. This included the glucometers. She also stated while both Resident #7 and Resident #11 had colonized infections, even colonized infections can potentially cause harm. She stated the facility followed the Center for Disease Control guidelines by continuing isolation precautions for residents with multi drug resistant infections for the remainder of their stay. On 06/29/10, the Director of Nursing revealed cleaning equipment between residents was essential to prevent the spread of infection

Based on the above findings, it was determined the facilities failure to prevent the spread of infection placed Resident #7 and any resident of the facility at risk for an additional infection which presents an imminent danger and creates a substantial risk that death or serious mental or physical harm to a resident will occur. The Administrator was notified of the Type A Citation on 07/01/10.

ISSUED BY : Pam Kimmerow
TITLE: RN NC/I
DATE: 7/6/2010

RECEIVED BY: Leigh Jenkins
TITLE : Director of Nursing
DATE: 7/6/2010

DATE TO BE CORRECTED :
CORRECTED DATE: 7/1/2010